Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932640	A. BUILDING: _____ B. WING _____	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLA OF BOYNTON BEACH	1935 SOUTH FEDERAL HIGHWAY BOYNTON BEACH, FL 33435

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A 000	Initial Comments An unannounced Relicensure, Complaint (#2019019687, #2020017453, #2021015956, #2022005012, #2022005547) and Generator Monitoring survey was conducted on ..... through ... at Grand Villa of Boynton Beach. The facility had deficiencies related to the Relicensure and Complaint #2021015956 and #2022005547 at the time of the survey.	A 000		
A 025	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility shall notify a licensed physician when a resident exhibits signs of or ... , ... or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such or . The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making ... for the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange with the appropriate health care provider for the necessary care and services to treat the condition. 59A-36.007 Resident Care Standards. An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal	A 025		

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A 025	Continued From page 1 supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with Rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on record review and interviews, the facility failed to provide adequate supervision and implement measures to reduce incidence of events resulting in . . . for 1 of 9 sampled residents (Resident #11). The findings included: Review of a report filed by the facility on revealed that Resident #11, an elderly female, was observed on the floor in the television area	A 025		

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A 025	Continued From page 2 laying on her [illegible] between chairs. Resident #11 stated she hit her [illegible] on the chair but could not recall how she [illegible]. The report revealed that the resident's wheelchair was within limits. 911 Emergency was activated at 4:05 PM. The admission records showed that Resident #11 was admitted to the facility on [illegible] and was discharged on [illegible]. Review of the initial Health Assessment (AHCA Form 1823) dated [illegible] revealed that Resident #11 was admitted to the facility with the diagnosis of [illegible], but pleasant. The record showed that she could ambulate independently. Review of the most recent Health Assessment (AHCA form 1823) dated [illegible] revealed that the resident required a care level of 4 for all activities of daily living. The level of care 4 highlighted that she was at risk for [illegible] and required assistance for ambulation, bathing, [illegible], selfcare grooming, toileting and transferring. However, after many [illegible], the Health Assessment was updated on [illegible] showing in bold characters that Resident #11 required special precautions for "[illegible]". Yet, in the days that followed Resident #11 sustained multiple [illegible] with no one present to prevent the [illegible] or provide the required documented assistance. a) On [illegible] at 6:30 PM, it was reported that the resident [illegible] when trying to sit down in her wheelchair. b) On [illegible] it was also noted that Resident #11 [illegible] on the lobby floor and was consequently transferred to the hospital for higher level of care. The diagnoses from that [illegible] were [illegible] injury, [illegible], and hematoma. c) On [illegible], it was documented that Resident #11 sustained another [illegible]. She was	A 025		

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A 025	Continued From page 3 found on the floor and again hit her . . . . She was transferred to the hospital. Review of the Progress Notes dated which referenced the . . that happened on , revealed that the resident was sitting in the TV room, in her wheelchair when she . . The wheelchair was unlocked at the time of the . . . Thereafter, a hospice consult was done as requested by the family. Furthermore, the resident was transferred to the Emergency room and returned to the facility requiring a higher level of care. The resident was then moved to the Memory Care Unit due to . decline and concerns. However, the Observation Notes revealed that Resident #11 was discharged from the facility on . . . . . . During an interview conducted with the Resident Care Manager (RCM) on at 12:57 PM, she reported that she started working at this facility in , . . The RCM reported that the . which occurred on . . . . . resulted from Resident #11 trying to self-transfer from a wheelchair to a chair. The resident lost her balance, , and hit her on the floor. The RCM informed that there was an investigation conducted about the incident. However, she failed to show evidence of the interventions put in place to reduce or prevent further . She said that one staff was interviewed during that investigation. No one else was interviewed to inquire about the events preceding the . . She also stated that regarding the that occurred on . . . . . , she did not interview any resident care associates (RCA) regarding that . She said that she requested a , ... screening from hospice as an intervention. During the exit conference with the facility's	A 025		

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A 025	Continued From page 4 Managers on . . . . . the issues were discussed and no additional information was provided. Class III	A 025		
A 032	59A-36.007(7) FAC Resident Care - Elopement Standards 59A-36.007 (7) ELOPEMENT STANDARDS. (a) Residents Assessed at Risk for Elopement. All residents assessed at risk for elopement or with any history of elopement must be identified so staff can be alerted to their needs for support and supervision. All residents must be assessed for risk of elopement by a health care provider or a mental health care provider within 30 calendar days of being admitted to a facility. If the resident has had a health assessment performed prior to admission pursuant to paragraph 59A-36.006(2)(a), F.A.C., this requirement is satisfied. A resident placed in a facility on a temporary emergency basis by the Department of Children and Families pursuant to Section 415.105 or 415.1051, F.S., is exempt from this requirement for up to 30 days. 1. As part of its resident elopement response policies and procedures, the facility must make, at a minimum, a daily effort to determine that at risk residents have identification on their persons that includes their name and the facility's name, address, and telephone number. Staff trained pursuant to paragraph 59A-36.011(10)(a) or (c), F.A.C., must be generally aware of the location of all residents assessed at high risk for elopement at all times. 2. The facility must have a photo identification of at risk residents on file that is accessible to all	A 032		

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A 032	Continued From page 5 facility staff and law enforcement as necessary. The facility's file must contain the resident's photo identification upon admission or upon being assessed at risk for elopement subsequent to admission. The photo identification may be provided by the facility, the resident, or the resident's representative. (b) Facility Resident Elopement Response Policies and Procedures. The facility must develop detailed written policies and procedures for responding to a resident elopement. At a minimum, the policies and procedures must provide for: 1. An immediate search of the facility and premises, 2. The identification of staff responsible for implementing each part of the elopement response policies and procedures, including specific duties and responsibilities, 3. The identification of staff responsible for contacting law enforcement, the resident's family, guardian, health care surrogate, and case manager if the resident is not located pursuant to subparagraph (8)(b)1.; and, 4. The continued care of all residents within the facility in the event of an elopement. (c) Facility Resident Elopement Drills. The facility must conduct and document resident elopement drills pursuant to Section 429.41(1)(k), F.S. This Statute or Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure the supervision, staffing, or physical plant systems necessary to prevent the elopement of one 1 of 3 residents reviewed (Resident #12). The findings included:	A 032		

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A 032	Continued From page 6 During the survey conducted at the facility on through , a request was made for the facility's elopement policy. A review of the policy revealed that if an elopement is suspected, staff will immediately perform the following: - Check the resident sign-out log, medical [illegible] calendar and activity sign-up sheet to see if the resident is out of the community. - Perform a room to room search as well as a community search including stairwells, closets, offices, hallways and common areas. - Concurrently with the room to room search other staff shall immediately search the surrounding grounds of the community searching for the Resident in question in unlocked cars, shrubs, patios and any and all areas immediately surrounding the community. - Staff member in charge will notify the Executive Director. - Contact the responsible party or listed emergency contacts to inquire if they are aware of the resident whereabouts. If not, advise them we are looking for their loved one. - If 10 minutes has passed and the resident is not located, the staff member in charge at the time of suspected elopement shall call 911 and inform the authorities providing a complete physical description, name, special issues and any other relevant information to assist the authorities in locating the missing resident. A review of Resident #12 facility file and documents revealed the resident was admitted to the facility's Memory Care Unit (MCU) on [illegible]. A review of the Resident's Care Plan dated documents on page 1, III. Special Precautions/Instructions under Elopement Risk: Placement in Exit Controlled	A 032		

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A 032	Continued From page 7 Memory Care Neighborhood. A review of the Resident #12's Health Assessment 1823 form dated documented his diagnosis as , , , , and . On , Resident #12 eloped from the facility's MCU using a paper hole-punch to pry the double doors leading into/out of the MCU. A review of the facility cameras showed Resident #12 prying on the double doors of the MCU. Observation of the double-doors leading into/out of the MCU by this Surveyor on revealed double-doors used as the main entry into the MCU, and cameras on the inside ceiling by the doors. Observation of the double-doors revealed they are controlled by a Maglock that releases with the use of a keypad by an employee, or when the break (release) bar is engaged for a period of seconds. On at 2:08 PM this Surveyor pushed the release bar and there was an immediate audible alarm. However, the door did not open immediately. Observation of the door also revealed a small space between the magnet and the metal bar locks that keeps the door closed, which is where Resident #12 is alleged to have been prying with the hole-punch. On at 2:32 PM, this Surveyor and the Regional Quality Assurance Manager tested the main double-door of the MCU again from the inside. It immediately sounded an alarm and opened after a 40 second delay of pushing on the release bar. This Surveyor then walked down the hall and observed 2 cameras that appear to be	A 032		

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A 032	Continued From page 8 360-degree cameras in the ceiling. After entering the open area near the Activity Room, elevators and dining room, this Surveyor walked into the dining room and observed an Exit sign to the left. Upon walking to the Exit, this Surveyor observed an Exit door by the kitchen. A push on the release bar resulted in the door opening immediately. This Surveyor went out the door and observed that it opens to the outside (north) grounds and parking lot. Observation revealed there was no camera or alarm on or near the door at the time of observation on . This is the door the Resident #12 is said to have exited. In an interview conducted with the Regional Quality Assurance Manager and Regional Director of Operations on at 1:52 PM, the Regional Director of Operations stated Resident #12 used a hole-punch to pry the door open, walked through the main doors, came into the main Assited Living area, walked down the hallway and went into the main dining room. They both stated he went through the side door located in the dining room. They both stated there are no cameras in the Assited Living area, as observed by this Surveyor on . The Regional Quality Assurance Manager stated that it was their investigation that they determined he went out the side door in the dining room. She stated that the side door of the main dining room was propped open with the hole-punch that he was observed using on the facility cameras. She further stated the camera was able to see him walk down the hall, but not in the dining room as there are no cameras in the Assisted Living section. The Regional Quality Assurance Manager stated this occurred around 6:00 AM and that the main doors Resident #12 used to exit from the MCU sounded an alarm.	A 032		

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A 032	Continued From page 9 A review of the resident's facility Observation Notes with an entry dated at 4:00 PM, documented the Executive Director received a call from (Rehab Center) where Resident was receiving rehabilitation services. They were informed that the Resident has been exit seeking in the facility. Resident #12 returned to the facility from the Rehabilitation Center on . No documentation was observed in the resident's file indicating Resident #12 was assessed/reassessed to determine his risk for elopement after receiving this information. In an interview conducted with the Regional Quality Assurance Manager and Regional Director of Operations on at 1:56 PM, they stated they were informed of Resident #12's elopement by his wife who telephoned the facility to inform them that he was outside the facility, and that he has telephoned her to come pick him up. The facility was unaware of the elopement until the call from Resident #12's wife. In an interview conducted with the Resident #12's wife on . . . . . at 9:51 AM, she stated he used a patient chart board to pry the door open and left the facility. She stated he had a cell phone and called her to come get him. She further stated that Resident #12 informed her that he jimmied open the two doors with a chart board and got out. She stated he was out about 4 or 5 hours and that she called 911 right away and that the local City Police Department brought him to the facility. A review of the facility's Staff Schedules during 2021 revealed there was only one employee scheduled to work in the MCU during the 11:00 PM to 7:00 AM shift. Staff E is documented as working alone at the time of the elopement. Staff	A 032		

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A 032	Continued From page 10 F who was working in the Assisted Living side of the community, heard the door alarm alarming over her walkie talkie and went to the MCU to check on the resident rooms. Staff E was said to be providing care inside a resident room and was informed of the alarm. In an interview conducted with Staff D on . . . . . at 11:49 AM, she stated the resident was not at the facility too long, and that he did not want to be there. She stated he was always telling his wife that he did not want to be there. She stated he was okay but would always be a little agitated. In an interview on at 2:05 PM conducted with the Regional Quality Assurance Manager and Regional Director of Operations, the Regional Director of Operations stated the local City Police took him to (Local hospital) as they were not sure of his condition. In an interview conducted with the Regional Quality Assurance Manager and Regional Director of Operations on . . . . . at 2:11 PM, they stated they did not change anything structurally. At the time of survey there remained no camera or alarm on the door Resident #12 was stated to have exited the facility. On . . . . . at 3:40 PM, during the exit conference with the Regional Quality Assurance Manager, Regional Director of Operations and Regional Operation Manager, they were informed of the findings and no further information was provided. Class III	A 032		

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A 093	Continued From page 11	A 093		
A 093	59A-36.012(2) FAC Food Service - Dietary Standards (2) DIETARY STANDARDS. (a) The meals provided by the assisted living facility must be planned based on the current USDA Dietary Guidelines for Americans, 2010, which are incorporated by reference and available for review at: http://www.flrules.org/Gateway/reference.asp?No=Ref-04003, and the current summary of Dietary Reference Intakes established by the Food and Nutrition Board of the Institute of Medicine of the National Academies, 2010, which are incorporated by reference and available for review at: http://iom.edu/Activities/Nutrition/SummaryDRIs/~/media/Files/Activity%20Files/Nutrition/DRIs/New%20Material/5DRI%20Values%20SummaryTables%2014.pdf. Therapeutic diets must meet these nutritional standards to the extent possible. (b) The residents' nutritional needs must be met by offering a variety of meals adapted to the food habits, preferences, and physical abilities of the residents, and must be prepared through the use of standardized recipes. For facilities with a licensed capacity of 16 or fewer residents, standardized recipes are not required. Unless a resident chooses to eat less, the facility must serve the standard minimum portions of food according to the Dietary Reference Intakes. (c) All regular and therapeutic menus to be used by the facility must be reviewed annually by a licensed or registered dietitian, a licensed nutritionist, or a registered dietetic technician supervised by a licensed or registered dietitian, or a licensed nutritionist to ensure the meals meet the nutritional standards established in this rule. The annual review must be documented in the	A 093		

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A 093	Continued From page 12	A 093		

facility files and include the original signature of the reviewer, registration or license number, and date reviewed. Portion sizes must be indicated on the menus or on a separate sheet.
1. Daily food servings may be divided among three or more meals per day, including snacks, as necessary to accommodate resident needs and preferences.
2. Menu items may be substituted with items of comparable nutritional value based on the seasonal availability of fresh produce or the preferences of the residents.
(d) Menus must be dated and planned at least 1 week in advance for both regular and therapeutic diets. Residents must be encouraged to participate in menu planning. Planned menus must be conspicuously posted or easily available to residents. Regular and therapeutic menus as served, with substitutions noted before or when the meal is served, must be kept on file in the facility for 6 months.
(e) Therapeutic diets must be prepared and served as ordered by the health care provider.
1. Facilities that offer residents a variety of food choices through a select menu, buffet style dining, or family style dining are not required to document what is eaten unless a health care provider's order indicates that such monitoring is necessary. However, the food items that enable residents to comply with the therapeutic diet must be identified on the menus developed for use in the facility.
2. The facility must document a resident's refusal to comply with a therapeutic diet and provide notification to the resident's health care provider of such refusal.
(f) For facilities serving three or more meals a day, no more than 14 hours must elapse between the end of an evening meal containing a protein

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 093	Continued From page 13 food and the beginning of a morning meal. Intervals between meals must be evenly distributed throughout the day with not less than 2 hours nor more than 6 hours between the end of one meal and the beginning of the next. For residents without access to kitchen facilities, snacks must be offered at least once per day. Snacks are not considered to be meals for the purposes of . . . . . the time between meals. (g) Food must be served attractively at safe and palatable temperatures. All residents must be encouraged to eat at tables in the dining areas. A supply of eating ware sufficient for all residents, including adaptive equipment if needed by any resident, must be on . . (h) A 3-day supply of nonperishable food, based on the number of weekly meals the facility has with residents to serve, must be on . . at all times. The quantity must be based on the resident census and not on licensed capacity. The supply must consist of foods that can be stored safely without refrigeration. Water sufficient for drinking and food preparation must also be stored, or the facility must have a plan for obtaining water in an emergency, with the plan coordinated with and reviewed by the local disaster preparedness authority. This Statute or Rule is not met as evidenced by: Based on observation, interviews, and record review the facility failed to store 3-days of emergency supply of nonperishable foods, based on the facility's current resident census of 102 out of its total capacity of 148 residents. The findings included: On /3022, the Manager in charge reported that the facility's current residents census was 102. From that sample fourteen residents resided	A 093		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11932640	A. BUILDING: _____ B. WING _____	09/02/2022

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A 093	Continued From page 14 in the Memory Care Unit and 88 resided in the Assisted Living Facility. 1) On at 12:20 PM, during review of the emergency food storage room, the following was noted: the number of non-perishable foods stored for emergency purposes was insufficient to meet the needs of the total number of residents residing at the facility for three days, according to review of the dietitian's report. Multiple can foods expired in . . . . . (Photographic evidence was obtained). 2) A phone call to the food product supplier (name of supplier) informed that the shelf life of those expired foods is two years. 3) Based on review of the Dietitian's report, the missing items were noted since . . . . . As of , the missing items were not replenished. The missing supplies were: Whole Potatoes 108 oz (ounce); Beef Ravioli 106 oz; Pinto Beans 111 oz; dried milk 100-8 oz; Yams 106 oz; and Chili 107 oz. Additionally, the Cream Slice Beef expired on . . . . . During an interview conducted with the facility's Food Service Manager on at 12:20 PM, he stated he has not yet met with the Dietitian. The findings were shared with the Administrator at the exit meeting on . . . . . , and no additional information was provided. Class III	A 093		